



Commonwealth of Kentucky  
Department for Medicaid Services  
Division of Program Quality and Outcomes

Managed Care Program Progress Report  
IPRO/DMS Contract Year  
7/1/2015–6/30/2016

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IPRO Corporate Headquarters  
Managed Care Department  
1979 Marcus Avenue  
Lake Success, NY 11042-1002  
phone: (516) 326-7767  
fax: (516) 326-6177  
[www.ipro.org](http://www.ipro.org)

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## Background and Introduction

The Commonwealth of Kentucky's report, Strategy for Assessing and Improving the Quality of Managed Care Services, outlines a strategy for quality oversight that is aligned with federal regulations and pursuant to the Social Security Act (Part 1915<sup>1</sup> and Part 1932(a)<sup>2</sup>), the Balanced Budget Act of 1997 and Title 42,<sup>3</sup> Part 438 of the Code of Federal Regulations (CFR).<sup>4</sup>

According to the Social Security Act (42 CFR Part 1932(a)) all states that contract with Medicaid managed care organizations (MCOs) to provide Medicaid services are required to provide for an external independent quality review. The Balanced Budget Act of 1997 further described mechanisms states should use in monitoring Medicaid MCO quality. In early 2003, the Centers for Medicare and Medicaid Services (CMS) issued a final rule defining the requirements for external quality review (EQR) and state quality monitoring<sup>5</sup> which include three mandatory external review activities and five optional activities. In July 2016, CMS revised the requirements and issued a final rule for Medicaid and Children's Health Insurance Program (CHIP) managed care and EQR. However, states are not required to implement the new requirements related to EQR until July 2018. The Cabinet for Health and Family Services (CHFS), Department for Medicaid Services (DMS) is responsible for administering and overseeing the Kentucky Medicaid Managed Care (MMC) Program. DMS contracts with an external quality review organization (EQRO), the Island Peer Review Organization (IPRO), to conduct the three mandatory review activities as well as many of the optional activities. The Kentucky EQR work plan includes the following review activities:

- § Validate performance improvement projects (PIPs)
- § Validate plan performance measures (PMs)
- § Conduct review of MCO compliance with state and federal standards
- § Validate encounter data
- § Validate provider network submissions
- § Conduct focused studies
- § Prepare an annual technical report
- § Develop a quality dashboard tool
- § Develop an annual health plan report card
- § Conduct a comprehensive evaluation summary
- § Develop PMs
- § Conduct access and availability surveys as needed

In addition to the mandatory and optional activities listed in federal regulation, Kentucky also contracts with their EQRO to validate patient level claims, conduct individual case reviews, pharmacy reviews, an annual Early Periodic Screening, Diagnostic and Treatment Services (EPSDT) review and an annual progress report. Technical assistance and presentations are provided as needed. The role of external quality review in Kentucky MMC is documented in the *Quality Companion Guide*. Prepared by the EQRO, this document is intended to assist MCOs in carrying out quality improvement activities and includes background information on EQR regulations and the role of the EQRO, instructions and time lines related to compliance review, PIP validation and PM validation.

The purpose of this Progress Report is to summarize information from the external quality review activities that describe the status and progress that has occurred in Kentucky's MMC Program during the contract period of July 1, 2015 through June 30, 2016. Key reports referenced while preparing this Progress Report include the following:

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<sup>1</sup> [http://www.ssa.gov/OP\\_Home/ssact/title19/1932.htm](http://www.ssa.gov/OP_Home/ssact/title19/1932.htm)

<sup>2</sup> <http://www.govtrack.us/congress/bills/105/hr2015>

<sup>3</sup> [http://www.ecfr.gov/cgi-bin/text-](http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=b4058b30e1d1a47b9abd147b7dced4cc&rgn=div5&view=text&node=42:4.0.1.1.8&idno=42#PartTop)

[idx?c=ecfr&sid=b4058b30e1d1a47b9abd147b7dced4cc&rgn=div5&view=text&node=42:4.0.1.1.8&idno=42#PartTop](http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=b4058b30e1d1a47b9abd147b7dced4cc&rgn=div5&view=text&node=42:4.0.1.1.8&idno=42#PartTop)

<sup>4</sup> 42 CFR Part 438.

<sup>5</sup> For the most recent EQR protocols, refer to <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>

- § Commonwealth of Kentucky's Strategy for Assessing and Improving the Quality of Managed Care Services, September 2012
- § 2016 External Quality Review Technical Report for MCO contract year(s) 2013–2015
- § Quality Companion Guide Final Version, July 2015
- § 2016 MCO Compliance Review findings
- § Quarterly Desk Audit Reports, 4<sup>th</sup> Quarter 2015
- § A Member's Guide to Choosing a Medicaid Health Plan 2015<sup>6</sup>
- § Kentucky Medicaid Management Information System (MMIS) Encounter Data Validation Report, May 2016
- § Validation of Managed Care Provider Network Submissions: Audit Report, January 2016
- § Web-Based Provider Directory Validation Study, January 2016
- § Validation of Performance Measures Report, April 2016
- § Access and Availability Survey - Dental Services, February 2016
- § Focused Study: Emergency Department Visits for Non-traumatic Dental Problems Among the Adult Kentucky Medicaid Managed Care Behavioral Health Subpopulation, May 2016
- § Focused Study: Prenatal Smoking, July 2016

## Managed Care Organizations

During the state fiscal year July 1, 2015 through June 30, 2016, five MCOs served the Medicaid population in Kentucky: Anthem Blue Cross and Blue Shield (BCBS) Medicaid; Coventry Health and Life Insurance Company (doing business as (dba) CoventryCares of Kentucky); Humana-CareSource; Passport Health Plan; and WellCare of Kentucky, Inc.

As a result of the Patient Protection and Affordable Care Act (ACA), March 2010, Medicaid eligibility was expanded in Kentucky and as of July 2015, all five MCOs were contracted to enroll members statewide.

## Enrollment/Regions

Enrollment in Kentucky's MMC Program steadily increased over the past year. On June 29, 2015, 1,162,413 Medicaid beneficiaries were enrolled in MMC and as of June 6, 2016, there were 1,229,921 enrolled, an increase of 5.8%. During this period, enrollment in Aetna Better Health decreased by approximately 7%, while enrollment in the other four plans increased. Anthem BCBS Medicaid and Passport Health Plan saw the highest percent increases in enrollment, 43.9%<sup>7</sup> and 13.6% respectively. WellCare of Kentucky continues to have the largest enrollment with 438,798 members (Table 1).

<sup>6</sup> [http://www.chfs.ky.gov/NR/rdonlyres/7BD9A46D-6710-4915-8163-](http://www.chfs.ky.gov/NR/rdonlyres/7BD9A46D-6710-4915-8163-4394F8F36EFF/0/2016MembersGuidetoChoosingaMedicaidHealthPlan.pdf)

[4394F8F36EFF/0/2016MembersGuidetoChoosingaMedicaidHealthPlan.pdf](http://www.chfs.ky.gov/NR/rdonlyres/7BD9A46D-6710-4915-8163-4394F8F36EFF/0/2016MembersGuidetoChoosingaMedicaidHealthPlan.pdf) (English), Accessed June 13, 2016.

[http://www.chfs.ky.gov/NR/rdonlyres/7E4290C1-5F2C-411B-9D21-](http://www.chfs.ky.gov/NR/rdonlyres/7E4290C1-5F2C-411B-9D21-99AB4074B023/0/2016MembersGuidetoChoosingaMedicaidHealthPlanSpanishrevised.pdf)

[99AB4074B023/0/2016MembersGuidetoChoosingaMedicaidHealthPlanSpanishrevised.pdf](http://www.chfs.ky.gov/NR/rdonlyres/7E4290C1-5F2C-411B-9D21-99AB4074B023/0/2016MembersGuidetoChoosingaMedicaidHealthPlanSpanishrevised.pdf) (Spanish), Accessed June 13, 2016.

<sup>7</sup> Note that the large increase (43.9%) in Anthem Blue Cross and Blue Shield Medicaid's enrollment is not surprising, since the MCO began participating in the Kentucky Medicaid managed care program in mid-2014 and expanded their service area and age groups served thereafter.

Table 1: Medicaid Enrollment Between June 29, 2015 and June 6, 2016

MCO	Enrollment 6/29/2015	Enrollment 6/6/2016	Percent Change	Percent of Total Medicaid Enrollment	Service Area
Anthem BCBS Medicaid	71,696	103,190	+43.9%	7.6%	Statewide
CoventryCares of Kentucky	293,370	272,680	-7.1%	20.0%	Statewide
Humana-CareSource	115,980	127,362	+9.8%	9.3%	Statewide
Passport Health Plan	253,536	287,891	+13.6%	21.1%	Statewide
WellCare of Kentucky	427,831	438,798	+2.6%	32.2%	Statewide
Managed Care Total	1,162,413	1,229,921	+5.8%	90.2%	Statewide
Fee-for-Service	121,576	134,213	+10.4%	9.8%	Statewide
Total Medicaid	1,283,989	1,364,134	+6.2%	100.0%	Statewide

MCO: managed care organization; BCBS: Blue Cross and Blue Shield

### Responsibility for Program Monitoring

DMS oversees the Kentucky MMC Program and is responsible for contracting with Medicaid MCOs, monitoring their provision of services according to federal and state regulations and overseeing the state's Quality Strategy as well as each MCO's quality program. DMS contracts with an EQRO to assist the state in conducting external reviews and evaluations of state and MCO quality performance and improvement.

The DMS Division of Program Quality and Outcomes (DPQ&O) measures, analyzes and reports health outcomes of Kentucky Medicaid members and the MCOs' compliance with all federal and state regulations and contract provisions. The DPQ&O consists of three branches: the Disease and Case Management Branch, the Managed Care Oversight – Quality Branch, and the Managed Care Oversight – Contract Management Branch.

The Disease and Case Management Branch reviews MCO and FFS disease and case management programs; oversees the EPSDT benefit; coordinates state fair hearings for Medicaid service denials; and coordinates disenrollment for cause requests.

The Managed Care Oversight – Quality Branch oversees the EQRO's measurement of the MCOs' quality outcomes; monitors the EQRO's contract compliance; reviews and analyzes the Healthcare Effectiveness Data and Information Set (HEDIS®) scores and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey results, and works with the EQRO to monitor the quality and effectiveness of care provided by the MCOs.

The Managed Care Oversight – Contract Management Branch reviews the MCOs' activities to monitor compliance with all applicable regulations and contract provisions; ensures that the MCOs consistently provide reliable health care to Kentucky's MMC members; and issues corrective action plans when an MCO is found in violation of a contract provision(s).

### Benefits

Kentucky's MMC Program offers a comprehensive benefit plan for enrollees.<sup>8</sup> Enrollee benefit information is made available to new enrollees as they become eligible and to all enrollees during the open enrollment period. Information regarding benefits is provided on the DMS Medicaid website, Member Information page. The Kentucky Medicaid

<sup>8</sup> <http://chfs.ky.gov/NR/rdonlyres/82416E1B-5D96-4FF7-AB27-0CB231416771/0/YourKYMedicaidBenefitPlan.pdf>, Accessed June 22, 2016.

Member Handbook<sup>9</sup> also provides an overview of the benefits members are entitled to receive through the Kentucky Medicaid Benefit Plan.

As of January 1, 2014, all Medicaid beneficiaries were provided with the same benefit plan. The Benefit Plan covers basic medical services including acute inpatient hospital services; outpatient hospital/ambulatory surgical centers; laboratory, diagnostic and radiology services; physician office visits; preventive services; EPSDT services; emergency ambulance and hospital emergency room services; occupational, physical and speech therapy; hospice, chiropractic, hearing and vision services; prosthetic devices; and durable medical equipment. Also included in the benefit package are behavioral health services; dental services; maternity services; prescription drugs; home healthcare; substance abuse treatment; family planning; podiatry services; and end-stage renal disease treatment and transplants. While a number of services require a small co-payment, some people covered by Medicaid are exempt, including non-KCHIP (children not in Kentucky's Children's Health Insurance Program), children under 19 years who are in foster care, pregnant women, Native Americans, as well as people receiving hospice care and home care. Services exempt from co-payment include family planning, preventive care, and services provided by American Indian Health Services providers. While the Benefit Plan sets co-payments and limits for each benefit category, the Medicaid MCOs may opt to augment the benefits and/or services by reducing or eliminating co-payments and offering additional services such as member rewards and gift incentives, free mobile phone service, and 24-hour nurse advice lines, to name a few.<sup>10</sup>

## Data Systems Validation

Medicaid MCOs in Kentucky are required to maintain a Management Information System (MIS) to support all aspects of managed care operation including member enrollment, encounter data, provider network data, quality performance data, claims and surveillance utilization reports to identify fraud and/or abuse by providers and members. The MCO must verify through edits and audits, the accuracy and timeliness of the information contained in their databases. MCOs are expected to screen for data completeness, logic and consistency. The data must be consistent with standard procedure codes, diagnosis codes and other codes as defined by DMS and in the case of HEDIS data, as defined by the National Committee for Quality Assurance (NCQA).

The EQRO is responsible for validating encounter data, provider network data and MCO-reported Kentucky PMs.

## Encounters

Encounters are defined as professional face-to-face transactions between an enrollee and a provider and are submitted to DMS weekly or at least monthly. All five MCOs submitted encounters during this review period.

The EQRO receives a final extracted file from DMS each month for further processing and then prepares a monthly data validation report summarizing each MCO's submission. The report format consists of two parts, a file validation report and an intake report. Each section presents data for all MCOs in aggregate and for each MCO separately. The validation report presents the number and percent of missing data and the number and percent of invalid data for each encounter variable. A separate validation table is created by encounter type including inpatient, outpatient, professional, home health, long-term care, dental and pharmacy. The intake report presents the number of encounters submitted to Kentucky MMIS and includes encounter volume reports by place of service.

## Monthly Encounter Data Validation Report

According to the Intake Report portion of the Monthly Encounter Data Validation Report prepared for June 2016, for the period between May 2015 and May 2016, the average number of encounter records per month was 10.5 million. Total encounter records ranged from a high of 15.4 million in June 2015 to a low of 6.5 million in September 2015. Additionally, the total number of monthly encounter records received declined from 12.4 million to 9.2 million between May 2015 and May 2016. This could be due to normal fluctuations. Several variables continued to show a high proportion of missing data elements including inpatient diagnosis codes 4 and above, inpatient procedure codes, inpatient surgical International Classification of Diseases, Revision 9 (ICD-9) codes 2 and above, performing provider key,

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<sup>9</sup> <http://www.chfs.ky.gov/NR/rdonlyres/A9BEAC84-BAEE-4FA1-9B84-CDD5CB390667/0/OpenEnrollment2016Master.pdf>, Accessed June 22, 2016.

<sup>10</sup> <http://www.chfs.ky.gov/NR/rdonlyres/A9BEAC84-BAEE-4FA1-9B84-CDD5CB390667/0/OpenEnrollment2016Master.pdf>, Accessed June 22, 2016.



procedure modifier codes, referring provider key, and all outpatient surgical ICD-9 codes. For May 2016, several key elements of provider-related information were missing, including national provider identification (NPI) number (51.4% of records), provider license number (44.0% of records) and taxonomy (51.7% of records).

### Encounter Data Validation Study-MCO Discrepancy Report

Accurate capture of MCO encounters is beneficial to DMS for future data collaborations, health care quality improvement studies and assessing measures of MCO performance. In order to confirm the accuracy of MCO encounter claims submitted to DMS, IPRO performs a data validation annually to ensure that DMS's data warehouse captures all data submitted by the MCOs. IPRO is conducting the data validation study for State Fiscal Year (SFY) 2016. IPRO requested the following from DMS: the most current file specifications sent to MCOs for encounter, dental and pharmacy data submissions, any updates to the data submission process since IPRO's prior review, and documentation of internal queries and edit checks applied to files received. IPRO reviewed the documentation and then requested that each of the Kentucky MCOs submit to IPRO the encounter data that were submitted to the state for the three month period, July–September 2015. An analysis and comparison of records and dates of service was conducted between the MCOs' and DMS data warehouse contents for encounter, dental and pharmacy data. Discrepancy reports were created for and provided to each of the MCOs. The MCOs were asked to provide responses with the reasons for the differences in the State MMIS system. Currently, the MCOs are preparing the responses.

### Provider Network

Kentucky MCOs each maintain a provider network database that requires continual updates and submission to DMS on at least a monthly basis. MCOs use the data to populate printed provider directories and on-line provider query tools for members and potential members. Each MCO uses their provider network database to create and submit required GeoAccess reports to DMS. In September 2015 and again in March 2016, IPRO completed two audits of the Kentucky MCOs' provider network submissions and concurrent validations of the MCOs' web-based provider directories.

### Validation of Managed Care Provider Network Submissions

For the Provider Network validation, two surveys were performed during the year. A sample of providers was randomly selected from each MCO's electronic provider directory files. Surveys were sent to 100 primary care providers and 100 specialists from each MCO to validate the information contained in the MCOs' provider directories. Information to be validated included elements such as name, provider license number, NPI, specialty(ies), language(s) spoken. The overall response rate was 58.1% in September 2015 and 60.6% in March 2016. In both audits, the providers' responses validated that some information in the Managed Care Assignment Processing System (MCAPS) data system was correct while other information required correction. For the September 2015 survey, a total of 206 of 456 providers (45.2%) returned a survey noting at least a revision to at least one element was necessary. For the March 2016 survey, a total of 219 of 467 providers (46.9%) returned a survey noting at least a revision to at least one element was necessary. Survey items where a substantial percentage of MCO data were missing included: provider license number, secondary specialty, Spanish and other languages spoken. IPRO sent plan-specific reports to each of the MCOs that included a list of revisions needed and a list of incorrect provider addresses. The MCOs were asked to update their provider directory files with the correct information.

Based on the findings from the Provider Network Validation studies, the EQRO made the following recommendations:

- § MCOs should improve the accuracy and completeness of critical fields in the provider directory data files, especially fields relating to license number, phone number, address, and languages.
- § DMS should consider enhancing the MCAPS provider file data dictionary with more specific definitions for the data elements.
- § DMS should consider adding data elements to the directory that collect information about wheelchair access, hours at site and provider's usage of EMRs.
- § DMS should consider removing the field "Spanish" and incorporating it into the Language field.
- § DMS should consider recording "Secondary Specialty" on the same row as "Primary Specialty" instead of on separate rows.

### Web-Based Provider Directory Validation

The Provider Web Directory Validation was performed to ensure that enrollees receive accurate information when they access the MCOs' web-based provider directories. The objectives of this study were two-fold: 1) to determine if all

providers included in the MCOs' electronic provider directory files are listed in the web-based provider directories, and 2) to ensure that provider information published in the MCO's' web directories is consistent with the information reported in the provider directory files and/or the provider network validation responses.

This study used provider directory files from September 2015 submitted by the MCOs. A random sample of 50% of providers who responded to the Provider Network Validation Study was drawn. Of those, no more than 50 providers from each MCO (25 primary care providers [PCPs] and 25 specialists) were chosen for audit. Overall, 97% of the PCPs and 77% of the specialists were found in the MCO online web directories. The accuracy of the web directory data was evaluated by comparing the information published in the MCO web directories to both the MCOs' provider directory files and the provider validation survey responses. If the web-based data matched either the provider directory files or the provider's survey response, the information was considered to be accurate. The overall accuracy rate of the provider information published in the web directories was determined to be 80% for PCPs and 88% for specialists.

One study limitation in the methodology for the web-based provider directory validation was that the study sample included only providers who responded to the Provider Network Survey and, therefore, excluded a portion of the full provider population in the MCAPS. Additionally, IPRO recommended that the web-based directory validation should also include a measure to indicate whether the web directory information is more consistent with the MCAPS file or the provider network survey responses. This would allow DMS to target data improvement to the appropriate source.

A second web directory validation was initiated in March 2016. This study used provider directory files from February 2016 submitted by the MCOs. A random sample of 50% of providers who responded to the Provider Network Validation Study was drawn. Of those, no more than 50 providers from each MCO (25 PCPs and 25 specialists) were chosen for audit. Overall, 97% of the PCPs and 79% of the specialists were found in the MCO online web directories. The accuracy of the web directory data was evaluated by comparing the information published in the MCO web directories to both the MCOs' provider directory files and the provider validation survey responses. If the web-based data matched either the provider directory files or the provider's survey response, the information was considered to be accurate. The overall accuracy rate of the provider information published in the web directories was determined to be 68% for PCPs and 83% for specialists.

## Quality Performance

Quality performance data is the basis for quality assurance and improvement activities. MCOs contract with a certified HEDIS audit organization to conduct an NCQA-approved audit prior to submitting HEDIS data to DMS. Additionally, MCOs are required to contract with an NCQA-certified vendor to administer the CAHPS survey. Complete HEDIS 2015 and CAHPS 2015 data files were successfully submitted by CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan and WellCare of Kentucky in June 2015 for services provided in the 2014 measurement year (MY). Since Anthem BCBS Medicaid was a new plan in 2014, the MCO submitted only a partial set of measures. DMS elected not to rotate any of the HEDIS measures selected for rotation by NCQA. DMS is reviewing the possibility of HEDIS measure rotation for future submissions.

## Validation of Reporting Year 2015 Kentucky Medicaid Managed Care Performance Measures

The Kentucky Medicaid MCO contract requires annual reporting of DMS-designated PMs, including both HEDIS and state-specific PMs, that reflect Healthy Kentuckians 2010 and Healthy Kentuckians 2020 goals and health care priorities. Together, the measures address access to, timeliness of, and quality of care provided for children, adolescents and adults enrolled in managed care with a focus on preventive care, health screenings, prenatal care, as well as special populations (e.g., adults with hypertension and children with special health care needs [CSHCN]). IPRO validated the MCO-reported PMs for reporting year (RY) 2015 based on the CMS protocol: *Validating Performance Measures: A Protocol for Use in Conducting Medicaid External Quality Review Activities (updated 2012)*. The performance validation methodology included an information systems capabilities assessment; denominator validation; data collection validation; and numerator and rate validation.

After the validation was completed, each of the measures and specifications were reviewed for necessary clarifications, revisions and improvements for the RY 2016 measure set. The MCOs' feedback, lessons learned from calculating the measures, the results of the PM validation findings, and DMS priorities were considered. All RY 2016 measure



specifications were updated as necessary, including dates, diagnosis and procedure codes and applicable HEDIS specification updates.

### **MCO Performance Annual Health Plan Report Card**

The Annual Health Plan Report Card is a document in which IPRO summarized HEDIS 2015 quality performance data. It is Kentucky's consumer-friendly document entitled "A Member's Guide to Choosing a Medicaid Health Plan." The guide was included in mailings sent during the open enrollment period and is also available in both English and Spanish on the DMS MMC webpage.<sup>11</sup> A similar guide will be developed for the 2017 open enrollment period using HEDIS 2016 and CAHPS 2016 data.

### **MCO Performance Dashboard**

The MCO Performance Dashboard is a quality performance dashboard that pictorially presents national, statewide and MCO-specific performance on selected quality and satisfaction measures using graphs and charts. IPRO updated the dashboard using HEDIS 2015 data and the most recent version is posted on the internet.<sup>12</sup> The dashboard content is comprehensive, clearly displayed, user-friendly, and simple to navigate, allowing the user to obtain information quickly and easily.

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<sup>11</sup> <http://www.chfs.ky.gov/NR/rdonlyres/7BD9A46D-6710-4915-8163-4394F8F36EFF/0/2016MembersGuidetoChoosingaMedicaidHealthPlan.pdf> (English), Accessed June 13, 2016.  
<http://www.chfs.ky.gov/NR/rdonlyres/7E4290C1-5F2C-411B-9D21-99AB4074B023/0/2016MembersGuidetoChoosingaMedicaidHealthPlanSpanishrevised.pdf> (Spanish), Accessed June 13, 2016.

<sup>12</sup> <http://ky.mco.ipro.org/>

## Compliance with State and Federal Standards

On behalf of DMS, IPRO annually evaluates MCO performance against contract requirements and state and federal regulatory standards. In an effort to prevent duplicative review, federal regulations allow for use of the NCQA accreditation findings to deem regulatory compliance, where accreditation standards are determined equivalent to federal regulatory requirements. Currently, three of the five Kentucky MCOs are accredited by NCQA: CoventryCares of Kentucky, Passport Health Plan and WellCare of Kentucky. The newer MCOs, Anthem BCBS Medicaid and Humana-CareSource, have been preparing for accreditation and anticipate meeting the contract requirements for accreditation within three years. Since the Kentucky contract contains specific domains and requirements that are not addressed by the NCQA accreditation reviews, the state prefers to use a deeming policy based on prior MCO performance rather than deeming based on accreditation.

The annual compliance review for the contract year January 2015–December 2015 was conducted in January 2016. Two MCOs (Humana-CareSource and Passport Health Plan) received partial reviews, based on findings of compliance in the previous year. The three remaining MCOs received full reviews, i.e., an assessment of all domains and requirements. Data were collected from the MCOs prior to the survey (pre-onsite documentation submission), during the onsite review, and in follow-up (post-onsite documentation submission). All data and information submitted are considered in determining the extent to which the health plan is in compliance with the standards.

Contract requirements and regulations were addressed within the following domains (in order of review tool number):

1. Quality Measurement and Improvement
2. Grievance System
3. Health Risk Assessment (HRA)
4. Credentialing and Recredentialing
5. Access
- 5a. Utilization Management (UM)
6. Program Integrity
7. EPSDT
8. Delegation
9. Health Information Systems
10. Case Management/Care Coordination
- 12a. Enrollee Rights
- 12b. Member Outreach
13. Medical Records
15. Behavioral Health Services
16. Pharmacy Services

Reviewer findings for each domain formed the basis for assigning preliminary and final review designations. The standard designations used are listed in Table 2.

Table 2: Standard Designations for Compliance Review

Standard Designations for Compliance		Points
Full Compliance	MCO has met or exceeded the standard.	3
Substantial Compliance	MCO has met most requirements of the standard, but may be deficient in a small number of areas.	2
Minimal Compliance	MCO has met some requirements of the standard, but has significant deficiencies requiring corrective action.	1
Non-compliance	MCO has not met the standard and requires corrective action.	0
Not Applicable	The standard does not apply to the MCO.	N/A

Each element within a review domain receives one of the determinations listed in Table 2 and a corresponding score for each determination (3 points for full compliance; 2 points for substantial compliance; 1 point for minimal compliance; and 0 points for non-compliance). The numerical score for each review domain is then calculated by adding the points achieved for each element and dividing by the total number of elements. Thus, an MCO may have some elements within a domain determined minimally compliant or non-compliant, but when averaged with other elements found to be fully or substantially compliant, the overall finding for that domain may indicate substantial compliance. The overall compliance determination is assigned as follows:

- § Full Compliance: point range of 3.0
- § Substantial Compliance: point range of 2.0–2.99
- § Minimal Compliance: point range of 1.0–1.99
- § Non-compliant: point range of 0–0.99
- § Not Applicable: N/A

As with the prior compliance reviews, DMS directed that any elements found less than compliant in the prior review (2015) and the current review (2016) should be scored minimally compliant and any elements found less than compliant for the two (2) prior years (2014 and 2015) and the current review (2016) should be scored non-compliant.

## Compliance Review Findings

Table 3 summarizes the 2016 annual compliance review findings for each category reviewed. The MCOs receive preliminary findings and are permitted to submit responses for further review. The final findings are sent to both the MCOs and DMS. The DMS Corrective Action Plan and Letter of Concern Committee (CAP/LOC Committee) reviews the findings. The Division of Program Quality and Outcomes, Managed Care Oversight Quality Branch and the Managed Care Oversight Contract Management Branch work together to determine which domains and elements will require a letter of concern (LOC) and/or a corrective action plan (CAP) request for each MCO. The CAP/LOC Committee issues the LOCs and CAP requests to the MCOs. In general, the MCOs must provide a CAP for all elements deemed minimally compliant or non-compliant.

Table 3: Overall Compliance Determinations by Review Category – 2016

Tool #/ Review Area <sup>1</sup>	Anthem BCBS Medicaid		CoventryCares of Kentucky		Humana- CareSource		Passport Health Plan		WellCare of Kentucky	
	Point Average	Compliance Deter- mination	Point Average	Compliance Deter- mination	Point Average	Compliance Deter- mination	Point Average	Compliance Deter- mination	Point Average	Compliance Deter- mination
1. QI/MI	2.47	Substantial	2.74	Substantial	2.99	Substantial	2.98	Substantial	3.00	Full
2. Grievances	2.43	Substantial	2.68	Substantial	2.75	Substantial	3.00	Full	2.93	Substantial
3. HRA	1.83	Minimal	2.71	Substantial	3.00	Full	3.00	Full	2.57	Substantial
4. Credentialing/ Recredentialing	2.60	Substantial	2.92	Substantial	3.00	Full	2.71	Substantial	2.99	Substantial
5. Access	2.17	Substantial	2.82	Substantial	2.33	Substantial	2.50	Substantial	2.91	Substantial
5a. UM	2.90	Substantial	3.0	Full	3.00	Full	3.00	Full	3.00	Full
6. Program Integrity	2.08	Substantial	2.74	Substantial	3.00	Full	3.00	Full	2.89	Substantial
7. EPSDT	2.14	Substantial	3.00	Full	3.00	Full	2.50	Substantial	3.00	Full
8. Delegation	3.00	Full	2.92	Substantial	N/A	N/A	N/A	N/A	2.79	Substantial
9. Health Information Systems	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
10. Care Management	1.67	Minimal	2.79	Substantial	3.00	Full	3.00	Full	2.91	Substantial
12a. Enrollee Rights	2.83	Substantial	2.87	Substantial	2.67	Substantial	3.00	Full	3.00	Full
12b. Member Outreach	3.00	Full	3.00	Full	N/A	N/A	N/A	N/A	3.00	Full
13. Medical Records	1.92	Minimal	2.95	Substantial	N/A	N/A	3.00	Full	3.00	Full
15. Behavioral Health Services	1.29	Minimal	2.94	Substantial	2.83	Substantial	3.00	Full	2.92	Substantial
16. Pharmacy Services	2.86	Substantial	2.72	Substantial	2.60	Substantial	3.00	Full	2.85	Substantial
# Elements Requiring Corrective Action/# of Elements Reviewed (% Requiring Corrective Action) <sup>1</sup>	54/240 (22.5%)		33/759 (4.3%)		2/131 (1.5%)		0/136 (0%)		3/726 (0.4%)	

<sup>1</sup> The number (#) of elements reviewed for each domain and in total varies by MCO according to their applicability; N/A – Not applicable (deemed due to prior Full Compliance)  
BCBS: Blue Cross and Blue Shield; QI/MI: Quality Assessment and Performance Improvement/M Measurement and Improvement; HRA: Health Risk Assessment; UM: Utilization management; EPSDT: Early and Periodic Screening, Diagnostic, and Treatment; N/A: not applicable.

In 2016, the Health Information Systems domain was not reviewed for any of the MCOs since all were deemed fully compliant in prior reviews. The evaluation of this review area includes, but is not limited to, a review of policies and procedures for claims processing; claims payment and encounter data reporting; timeliness and accuracy of encounter data; timeliness of claims payments; and methods for meeting Kentucky Health Information Exchange (KHIE) requirements.

Passport Health Plan achieved full compliance for nine domains; both WellCare of Kentucky and Humana-CareSource attained full compliance for six domains; Aetna Better Health for three domains; while Anthem BCBS Medicaid earned full compliance for two domains.

Across all MCOs, the majority of review requirements (57%) exhibited substantial compliance, meaning that most requirements of the standards were met, but there were a small number of deficiencies identified. Many of the deficiencies noted were omissions or lack of clarity in the MCO policies and procedures, Provider Manuals, and/or Member Handbooks.

Only Anthem BCBS Medicaid received category-level determinations of less than substantial compliance; with four domains earning minimal compliance. None of the five MCOs received a category-level designation of non-compliance.

The number and proportion of elements reviewed eligible for corrective action (rating of minimal or non-compliance) ranged from a high of 22.5% (54 of 240 elements) for Anthem BCBS Medicaid to a low of 0% for Passport Health Plan. Of all elements reviewed for all five MCOs, 4.6% received minimal or non-compliant ratings that could require a CAP.

### **Program Integrity**

Maintaining program integrity includes guarding against fraud, abuse and deliberate misuse of Medicaid program benefits; ensuring that Medicaid enrollees receive necessary quality medical services; and ensuring that providers and recipients are in compliance with federal and state Medicaid regulations. In determining MCO compliance with federal and state regulations for program integrity, the EQRO's 2016 Compliance Review included, but was not limited to, an evaluation of MCO policies and procedures, training programs, compliance with Annual Disclosure of Ownership (ADO) and financial interest provisions and a file review of program integrity cases.

Overall compliance determinations for the Program Integrity domain varied. Both Passport Health Plan and Humana-CareSource achieved full compliance; while Anthem BCBS Medicaid, Aetna Better Health and WellCare of Kentucky earned substantial compliance. Anthem BlueCross BlueShield Medicaid and Aetna Better Health were required to prepare CAPs for elements found minimally compliant or non-compliant. No CAPs were required for the other three MCOs.

### **Health Risk Assessment**

Evaluation of the HRA domain included, but was not limited to, examination of MCO policies and procedures and a review of initial health screenings and MCO-initiated outreach to new members. The findings revealed that for this domain, Passport Health Plan and Humana-CareSource both achieved full compliance; Aetna Better Health and WellCare of Kentucky earned substantial compliance; while Anthem Blue Cross Blue Shield Medicaid was found to be in minimal compliance with the standards for HRA. All MCOs faced challenges in obtaining completed initial health risk assessments for newly enrolled members. Areas where compliance was lacking included: no documentation of assistance with PCP linkage and initial appointment scheduling and lack of referral to case management for needs identified in the HRA. All MCOs, except Humana-CareSource and Passport Health Plan, were required to submit at least one CAP.

### **Care Management/Coordination**

Care coordination is a key component of managed care and is based on the assurance that all enrollees have an ongoing source of primary care 24 hours a day, 7 days a week as well as access to all necessary care and services. The MCO plays a unique role in identifying individuals with special healthcare needs (including chronic physical, developmental, behavioral, neurological or emotional conditions) and offering care coordination through case management. MCOs identify enrollees in need of care coordination via HRAs completed for new enrollees and tracking indicators of need

using encounter data algorithms to identify high risk diagnosis codes, high utilization, repeated use of emergency rooms, frequent inpatient stays, and hospital readmissions.

The compliance domain Care Management and Coordination closely examines coordination of care efforts between the MCOs and Kentucky's Department of Community Based Services (DCBS) and the Department of Aging and Independent Living (DAIL). MCOs require access to baseline information from DCBS and DAIL to enable timely and appropriate member referrals and for MCO case managers to ensure enrollee access to needed services. The service plans maintained by DCBS and DAIL are a key source of this baseline information. Ongoing communication with DCBS/DAIL staff is also essential to coordinate the most appropriate services and address individual member's needs. The DMS Division of Program Quality and Outcomes, Disease and Case Management Branch has been working to facilitate communication between the state agencies and the MCOs, including convening collaborative workgroups and tracking MCO access to service plans.

The 2016 overall compliance determinations for Care Management and Coordination revealed that Humana-CareSource and Passport Health Plan achieved full compliance; Aetna Better Health and WellCare of Kentucky earned substantial compliance, while Anthem BCBS Medicaid was found minimally compliant. For the purposes of the 2015 and 2016 annual reviews, DMS designated the requirements related to service plans not applicable for the MCOs since the service plans are under the domain of DCBS and DAIL. The sole requirement for the MCOs was to demonstrate efforts to obtain service plans for their enrolled DCBS and DAIL members. Obtaining service plans, especially accurate and complete service plans has been an historical challenge for all MCOs. All MCOs demonstrated efforts to obtain service plans and to meet regularly with DCBS and DAIL. Opportunities for improvement identified by this review included: the need to develop and implement policies and procedures that ensure access to care coordination for all DCBS clients; improve tracking and analyzing performance indicators for DCBS clients and implementing corrective actions when warranted; and the need for policies and procedures that better address Pediatric Interface and school-based services.

### **Enrollee Rights and Responsibilities**

MCO Member Services is responsible for providing information to enrollees and responding to enrollee questions, problems and complaints. Member Services educates and assists enrollees to select or change their primary care provider. Member Services is also responsible for providing written information, such as a Member Handbook; explaining covered services; and providing instructions on how to access services. State and federal regulations call for cultural awareness and sensitivity in communicating with members and handling member grievances, cultural issues and program integrity. Kentucky Medicaid MCOs conduct ongoing monitoring of Member Services' functions by tracking the content and efficiency of calls including returned calls, call resolution, repeat callers and call abandonment rates. MCOs that utilize a subcontracted call center service must conduct careful vendor oversight and reporting.

The 2016 Compliance Review evaluation of the Enrollee Rights and Responsibilities domain included an assessment of policies and procedures for member rights and responsibilities, PCP changes and Member Services functions. For the Enrollee Rights domain, Passport Health Plan and WellCare of Kentucky achieved full compliance, while the remaining three MCOs, Anthem BCBS Medicaid, Aetna Better Health and Humana-CareSource earned substantial compliance. Humana-CareSource was required to submit one CAP and no CAPs were required of the remaining MCOs.

### **Quarterly Desk Audit Tables**

While DMS remains committed to conducting compliance reviews on an annual basis, in an effort to streamline the compliance review process for the MCOs, the EQRO initiated periodic desk audits of selected MCO statutory reports submitted to DMS on a quarterly basis. As a result, the EQRO is able to review quarterly report data concurrent with submission by the MCOs, rather than reviewing all the statutory report data in conjunction with the annual compliance review. IPRO is able to conduct these quarterly reviews by creating and completing Desk Audit Tables that address each MCO upon receipt of the MCO quarterly reports from DMS, concurrent with each MCO's quarterly submission to DMS. The desk audits address each of the following review areas:

- § Access and Availability
- § Continuity and Coordination (Case Management/Care Coordination)
- § Coverage and Authorization of Services (UM)
- § Enrollee Rights
- § Grievance System



## Provider Network Access

Kentucky Medicaid MCOs are required to maintain and monitor a network of appropriate providers and assure that there is adequate provider capacity that is sufficient in number, mix of specialty and geographic distribution. The MCOs conduct ongoing reviews of provider credentials and assure that enrollees receive timely access to services within designated time and travel parameters. Progress in meeting these contract provisions is described using compliance review findings along with access and availability survey findings, HEDIS Access and Availability measures, HEDIS Use of Services measures and CAHPS member satisfaction survey results.

### Compliance with Access Standards

The EQRO's Annual Compliance Review assessment of access included, but was not limited to a review of policies and procedures for direct access services, provider access requirements, program capacity reporting, evidence of monitoring program capacity and provider compliance with hours of operation and availability.

Findings from the 2016 Compliance Review related to provider network access indicated that all five MCOs received an overall rating of substantial compliance. WellCare of Kentucky, Passport Health Plan and Humana-CareSource had no elements requiring a corrective action plan, while Aetna Better Health and Anthem BCBS Medicaid had four and one elements requiring corrective action, respectively.

### Access and Availability Survey of Dental Providers

During CY 2016, DMS and IPRO collaborated to design and conduct a dental provider access and availability survey using a "secret shopper" methodology. All five Kentucky Medicaid MCOs participated in the survey: Anthem BCBS Medicaid, CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan, and WellCare of Kentucky. A random sample of 220 dentists was selected from each MCO's dental network.

The telephone survey was fielded between November and December 2015. Time was allowed for initial phone calls and recalls after obtaining updated phone numbers for some providers. The methodology consisted of several different dental appointment request scenarios depending on the type of dental provider and for an adult or child/adolescent member. Scenarios for both routine and urgent needs were used. The contract requirements for timely appointments are 21 days for a routine service and 48 hours for an urgent need. The telephone surveyors made up to four attempts to contact a live person at each provider office. If a live person was not reached, the surveyor did not leave a telephone number call-back.

Key findings included the following:

- § Overall, dental providers were contacted for 92.4% of routine calls and 88.2% of urgent calls.
- § Dental providers were reached and appointments were scheduled within the required timeframes for 35.2% of routine calls and 31.6% of urgent calls (i.e., 21 days and 48 hours, respectively).

When the survey was completed, each of the MCOs received a plan-specific summary report of dental providers who could not be contacted and those who could not provide an appointment within the required timeframe. MCOs were asked to review the reports and submit responses for files instances where providers who could not be reached and/or appointments that could not be made timely. IPRO reviewed the responses and submitted a report to DMS.

### Board Certification

Rates for the HEDIS 2015 Board Certification measure illustrate the percentage of physicians in an MCO's provider network who are board certified as of the last day of the MY (December 31, 2014) for the following specialties - family medicine, internal medicine, obstetrics/gynecology(OB/GYN), pediatrics, geriatrics and other specialties. Four of the five Kentucky Medicaid MCOs reported this measure for RY 2015 – CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan, and WellCare of Kentucky. Anthem Blue Cross and Blue Shield Medicaid did not report this measure in 2015. The board certification rates for family medicine physicians, OB/GYNs, pediatricians, and geriatricians were below the HEDIS 2015 national NCQA Quality Compass™ average for all MCOs. The rates for internists and other physicians were above the NCQA average rate only for CoventryCares of Kentucky.

## Access and Utilization – HEDIS 2015

HEDIS Access/Availability of Care and Utilization measures indicate the percentages of children, adolescents, and adults who access their PCP for preventive visits, outpatient services, dental services, and alcohol and other drug (AOD) dependence treatment. Timeliness and adequacy of prenatal and postpartum services, well-child visits, adolescent well-care visits and MCO call answer timeliness is also assessed.

Performance related to access and availability was a statewide area of strength. Measures for which Kentucky's HEDIS 2015 weighted statewide average met or exceeded the HEDIS 2015 national Medicaid 50<sup>th</sup> percentile included the following:

- § Adult Access to Preventive/Ambulatory Health Services: Total Rate;
- § Children and Adolescents' Access to Primary Care Practitioners (all age groups);
- § Annual Dental Visit (all age groups);
- § Prenatal and Postpartum Care: Timeliness of Prenatal Care; and
- § Frequency of Ongoing Prenatal Care: 81%+ of Expected Visits.

Although strong performance was demonstrated for some measures of access, opportunities for improvement remain. The HEDIS 2015 weighted statewide rate for Well-Child Visits in the First 15 Months of Life ( $\geq 6$  Visits); Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life; Adolescent Well-Care Visits; Call Answer Timeliness; and Initiation and Engagement of AOD Dependence fell short of the national Medicaid 50<sup>th</sup> percentile.

## Consumer Satisfaction with Access – CAHPS Health Plan Survey 5.0H 2015

Each of the five MCOs is required by DMS to conduct annual adult and child member satisfaction surveys. The CAHPS 5.0H Adult survey was sent to a random sample of members ages 18 years and older as of December 31, 2015 and continuously enrolled for at least five of the last six months of 2015. The child and adolescent CAHPS 5.0H satisfaction survey was sent to the parent/guardian of randomly sampled members ages 17 years and younger as of December 31, 2015 and continuously enrolled for at least five of the last six months of 2015.

Table 4 highlights CAHPS 5.0H 2015 measures related to access from the adult and child satisfaction surveys: Getting Care Quickly; Getting Needed Care; Doctor is Available When Needed; and Satisfaction with Customer Service. For both the adult and child surveys, the Kentucky statewide average was above the 2015 NCQA national Medicaid average for all four measures.

Table 4: CAHPS 2015 5.0H Adult and Child Satisfaction Survey – Access Measures

Measure	Anthem BCBS Medicaid	Coventry-Cares of Kentucky	Humana-CareSource	Passport Health Plan	WellCare of Kentucky	Statewide Average 2015
<b>Adult Survey</b>						
Get Care Quickly <sup>1</sup>	85.26%	81.48%	83.10%	81.55%	83.18%	83.0 %↑
Get Needed Care <sup>1</sup>	84.68%	83.27%	86.32%	83.21%	84.53%	84.4 %↑
Adult Doctor Available <sup>2</sup> (Q4)	88.61%	84.67%	87.58%	84.72%	83.49%	85.9 %↑
Customer Service <sup>1</sup>	89.17%	88.70%	96.36%	89.87%	90.56%	90.8% ↑
<b>Child Survey</b>						
Get Care Quickly <sup>1</sup>	90.90%	94.65%	87.84%	92.08%	89.75%	91.2 %↑
Get Needed Care <sup>1</sup>	83.58%	86.60%	81.32%	89.42%	88.25%	87.2 %↑
Child Doctor Available <sup>2</sup> (Q4)	91.84%	95.33%	91.76%	93.93%	88.73%	92.4 %↑
Customer Service <sup>1</sup>	86.16%	87.25%	91.52%	90.88%	85.40%	88.3 %↑

<sup>1</sup> These indicators are composite measures.

<sup>2</sup> Note: for measures that call for respondents to answer with "Always," "Usually," "Sometimes" or "Never" the Medicaid rate is based on responses of "Always" or "Usually."

↑ Arrow indicates Kentucky statewide average > 2015 NCQA Quality Compass national Medicaid average.<sup>13</sup>

<sup>13</sup> National Committee for Quality Assurance Quality Compass™, Medicaid CAHPS®2015.

## Quality Assessment and Performance Improvement

Quality Assessment and Performance Improvement (QAPI) is addressed in the EQRO's annual compliance review and includes, but is not limited to, a process review of each MCO's Health Information Systems, credentialing and delegation procedures, UM, Quality Improvement (QI) Program Description, Annual QI Evaluation, QI Work Plan and QI committee structure and function. In addition to processes and procedures, the EQRO reviews MCO performance including a compilation and analysis of the Medicaid MCOs' quality performance and satisfaction data. IPRO validated MCO PIPs, completed two focused clinical studies and conducted two additional focused clinical studies during the contract period. This section of the Progress Report outlines and describes the various quality assessment and improvement activities undertaken as part of Kentucky's MMC Program.

### Health Information Systems

As stated prior, the domain addressing the MCOs' Health Information Systems was not reviewed in 2016 because all MCOs were deemed due to full compliance in previous years.

### Credentialing

Kentucky Medicaid MCOs are responsible for ongoing review of network provider performance and credentials. As part of the 2016 Compliance Review, the EQRO assessed MCO written policies and procedures regarding the selection and retention of providers in their network. Providers, including individuals and facilities, must be validly licensed and/or certified to provide services in the state, and may also be accountable to a governing body for review of credentials for physicians, dentists, advanced registered nurse practitioners and vision care providers.

The 2016 Compliance Review findings for Credentialing/Recredentialing demonstrated that one MCO achieved full compliance (Humana-CareSource) while the remaining four MCOs earned substantial compliance.

### Delegation

With the approval of DMS, MCOs may execute subcontracts for the performance of administrative functions or the provision of services to members. The Kentucky Medicaid MCOs enlisted subcontractors for a variety of purposes, including for example, HEDIS data collection, claims processing, call center functions, and behavioral health, dental and vision provider networks. MCOs are required to provide written notification regarding all subcontracts to DMS quarterly and within ten days of termination of a subcontract.

The 2016 compliance evaluation of this domain comprised a review of subcontractor contracts and oversight, including subcontractor reporting requirements, pre-delegation evaluations and annual, formal evaluations. No review was required for Humana-CareSource and Passport Health Plan due to findings of full compliance ratings for this domain in prior years. Anthem BCBS Medicaid achieved an overall determination of full compliance for the Delegation domain, while Aetna Better Health and WellCare of Kentucky each earned substantial compliance.

### Utilization Management

A comprehensive UM program regularly reviews services for medical necessity and routinely monitors and evaluates the appropriateness of care and services. Each MCO's UM program must have mechanisms in place to ensure consistency in applying clinical review criteria and protocols. The EQRO review included an evaluation of UM policies and procedures, UM committee meeting minutes and a review of a sample of UM files. Four of the five MCOs earned full compliance for the UM domain, the exception was Anthem BCBS Medicaid, with an overall rating of substantial compliance. No MCOs had elements requiring a CAP.

### Quality Measurement and Improvement

The 2016 Compliance Review findings revealed that WellCare of Kentucky achieved full compliance for all Quality Measurement and Improvement standards, while Anthem BCBS Medicaid, CoventryCares of Kentucky, Humana-CareSource and Passport Health Plan each earned substantial compliance ratings. Of the four MCOs rated substantially compliant; Humana-CareSource, Passport Health Plan, and WellCare of Kentucky required no CAPs, while Aetna Better Health and Anthem BCBS Medicaid required 9 and 15 CAPs, respectively.

## Performance Measurement

Kentucky Medicaid PMs are derived from three annual data submissions to DMS: Kentucky PMs; HEDIS data, and the CAHPS consumer satisfaction results.

### Kentucky Performance Measures – Reporting Year 2015

Kentucky PMs, submitted annually to DMS, are validated by the EQRO according to the CMS protocol for PM validation. The performance validation methodology includes an information system capabilities assessment; denominator validation; data collection validation; and numerator validation. A final report is prepared, which includes all validation findings and a designation of reportable/not reportable for each of the measures.

General observations of the aggregate level performance (average rates for all MCOs) include:

- § Performance was very good for documentation of height and weight for both children and adolescents and adults, with rates above 75% for both.
- § Only approximately 24% of adults and 39% of children and adolescents had a healthy weight for height reported. It should be noted; however, that this measure is for reporting purposes only; MCOs are not held accountable for improvement.
- § The rates for the related measures, counseling for nutrition and physical activity for adults, were quite low at approximately 30%.
- § The rate for cholesterol screening for adults was fair, at 58.71%.
- § Adolescent screening and counseling rates ranged from a low of 34.32% (screening/counseling for sexual activity) to a high of 61.35% (screening/counseling for tobacco), with screening/counseling for alcohol/substance use and depression falling in between (44.54% and 36.76%, respectively).
- § For screening and counseling during the perinatal period, screening for tobacco was most often found (55.58%), followed by screening for alcohol use (51.88%) and substance use (49.54%).
  - Of the 312 (34.40%) women identified as tobacco users, only 61.25% had evidence of intervention.
  - Of the 59 (8.06%) women identified as alcohol users, only 22.43% had evidence of intervention.
  - Of the 93 (10.68%) women identified as substance users, only 61.92% had evidence of intervention.
- § Prenatal assessment/counseling for nutrition was found in 31.37% of records and counseling for use of prescription and/or over-the-counter medications was reported 50.98% of the time.
- § There is a substantial opportunity for improvement in screenings for domestic violence and depression. Rates were 25.16% for prenatal domestic violence screening, 33.98% for prenatal depression screening, and slightly higher at 39.42% for postpartum depression screening.
- § Access to dental care for CSHCN, as indicated by the HEDIS Annual Dental Visits measure, was fair for the total CSHCN population ages 2-21, at 59.22%, and ranged from a low of 52.84% for the SSI population to a high of 70.85% for the foster population.
- § Related to well-child visits for CSHCN, performance ranged from 45.24% for adolescent well-care visits to 71.17% for well-child visits for children 3–6 years of age.
- § All rates for access to care for CSHCN exceeded 90%. The rate was highest for those 12–24 months of age (98.04%), followed by 7–11 years of age (94.72%), 25 months–6 years of age (92.98%) and 12–19 years of age (92.44%).
- § The rate for 6 or more well-visits in the first 15 months of life was 47.57%.
- § The CMS-416 EPSDT dental services measures were reported for the first time in RY 2015. The rate for receipt of any dental service was 47.29% and the rate for preventive services was 40.13%. The aggregate rate for sealants on a permanent molar for children 6 and 11 years of age was very low, 5.02% and ranged from 1.80% to 5.49% across the five MCOs.

### Quality Performance – HEDIS 2015

DMS requires the MCOs to report HEDIS measure rates for the following domains: Board Certification, Effectiveness of Care, Access/Availability of Care and Use of Services. All five MCOs (Anthem BCBS Medicaid, CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan and WellCare of Kentucky) successfully submitted audited HEDIS data in June 2015 for services provided in MY 2014. This was the first year of reporting for Anthem BCBS Medicaid.

HEDIS 2015 results for Board Certification, Access and Use of Services were summarized previously, in the Provider Network Access section of this report. Results for the Effectiveness of Care measures are summarized below.

HEDIS Effectiveness of Care measures evaluate how well a health plan provides preventive screenings and care for members with acute and chronic illnesses, including: respiratory illnesses, cardiovascular illnesses, diabetes, behavioral health and musculoskeletal conditions. In addition, medication management measures are included.

A review of HEDIS 2015 Effectiveness of Care rates for the Kentucky MCOs revealed that many of the weighted statewide average rates compared favorably with HEDIS 2015 Medicaid Quality Compass 50<sup>th</sup> percentile including the following:

- § Adult BMI Assessment,
- § Immunizations for Adolescents, including Meningococcal, Tetanus, Diphtheria, Pertussis/Tetanus, Diphtheria booster (Tdap/Td) and Combination #1,
- § Use of Appropriate Medications for People with Asthma (Ages 5–11 Years, 12–18 Years, and Total),
- § Follow-up Care for Children Prescribed ADHD Medication (Initiation and Continuation/Maintenance Phases),
- § Annual Monitoring for Patients on Persistent Medications (ACE Inhibitors, Diuretics, Total),
- § Medication Management for People with Asthma: 75% Compliance (all age groups and Total), and
- § Comprehensive Diabetes Care:
  1. HbA1c Testing,
  2. Poor HbA1c Control (> 9.0%),
  3. HbA1c Control (< 8.0% and < 7.0%), and
  4. Medical Attention for Nephropathy.

Opportunities for improvement were identified by weighted statewide averages below the national Medicaid Quality Compass 10<sup>th</sup> percentile benchmark for the following measures:

- § Appropriate Treatment for Children with Upper Respiratory Infection,
- § Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis, and
- § Use of Imaging Studies for Low Back Pain.

### Consumer Satisfaction – CAHPS 2015

Statewide, the survey findings indicated that 73.8% of adults were satisfied overall with their healthcare in the managed care program and 78.4% were satisfied with their health plan. Statewide rates for these survey items were above the 2015 national Medicaid average. The child survey results demonstrated that 84.8% were satisfied overall with their child's healthcare and 83.5% were satisfied with their health plan; however, both rates fell just short of the CAHPS 2015 national Medicaid average.

## Quality Improvement

### Performance Improvement Projects (PIPs)

A protocol for conducting PIPs was developed by CMS to assist in the design and implementation of Medicaid performance improvement efforts. Additionally, federal MMC regulations require that all PIPs be validated according to CMS EQR protocols for PIP validation. In the Kentucky MMC Program, the EQRO is responsible for validating MCO PIPs. Each year, the MCOs initiate two new PIPs, each with baseline, interim and final measurements over a three-year duration; thus, in any given year, an MCO is likely to have two to six PIPs at various stages of activity in progress.

The EQRO's process for validating MCO PIPs begins with DMS approval of the PIP topic. Using a team of two reviewers, the EQRO evaluates the PIP proposals, including the topic selection, rationale, methodology, study indicators, and planned interventions. The MCOs receive written feedback and the findings are discussed via teleconferences. Subsequently, the EQRO follows all PIPs through each phase with written evaluations and discussions of the PIP progress and issues. Each PIP is assessed with a quantitative score at the interim and final re-measurement phases. The concurrent evaluation approach is a key method for validating the PIP results, but more importantly, it helps the MCOs to refine the indicators, methodology, and interventions prior to implementation. This allows the MCO identify and



address any issues early. The MCO benefits also from the perspective of multiple reviewers. The EQRO team is available for consultation at any time, should the MCO need assistance.

Initially, MCOs selected PIP topics based individually, usually based on HEDIS results. Subsequently, DMS initiated a contract requirement that MCOs conduct a PIP for one physical health and one behavioral health topic annually with each MCO selecting the specific topics. More recently, DMS has designated a collaborative, statewide topic. For 2015, the topic was use of antipsychotic medications for children and adolescents and for 2016, management of preventive care and physical health risks for people with serious mental illness (SMI). For the 2016 PIP, IPRO developed the PIP indicators and methodology and is assisting the MCOs with intervention development for this statewide improvement effort.

Table 5 presents a list of the Kentucky Medicaid MCOs' active PIP topics for 2012–2018.

Table 5: PIP Project Status 2012–2018

Plan	PIP Topic	Proposal Submitted	PIP Period
All-plans	Safe and Judicious Antipsychotic Medication Use in Children and Adolescents	2014	2015–2017
	The Effectiveness of Coordinated Care Management on Physical Health Risk Screenings in the Seriously Mentally Ill Population	2015	2016–2018
Anthem BCBS Medicaid	Reducing Avoidable Emergency Department Utilization	2014	2015–2017
	Increasing Annual Dental Visits	2015	2016–2018
Aetna Better Health Medicaid	Major Depression: Anti-Depressant Medication Management and Compliance	2012	2013–2015
	Decreasing Non-Emergent Inappropriate Emergency Department Use	2012	2013–2015
	Secondary Prevention by Supporting Families of Children with Attention Deficit Hyperactivity Disorder (ADHD)	2013	2014–2016
	Decreasing Avoidable Hospital Re-admissions	2013	2014–2016
	Increasing Comprehensive Diabetes Testing and Screening	2014	2015–2017
	Improving Postpartum Care	2015	2016–2018
Humana-CareSource	Untreated Depression	2013	2014–2016
	Emergency Department Use Management	2013	2014–2016
	Increasing Postpartum Visits	2014	2015–2017
	HbA1c Control	2015	2016–2018
Passport Health Plan	Reduction of Emergency Room Care Rates	2012	2013–2015 <sup>1</sup>
	Reduction of Inappropriately Prescribed Antibiotics for Pharyngitis and Upper Respiratory Infections (URI)	2012	2013–2015 <sup>1</sup>
	You Can Control Your Asthma! Development and Implementation of an Asthma Action Plan	2013	2014–2016
	Psychotropic Drug Intervention Program	2013	2014–2016
	Reducing Readmission Rates of Postpartum Members	2014	2015–2017
	Healthy Smiles	2015	2016–2018
WellCare of Kentucky	Utilization of Behavioral Health Medication in Children	2012	2013–2015
	Decreasing Inappropriate Emergency Department Utilization	2012	2013–2015
	Follow-up After Hospitalization for Mental Illness	2013	2014–2016
	Management of Chronic Obstructive Pulmonary Disease (COPD)	2013	2014–2016
	Postpartum Care	2014	2015–2017
	Pediatric Oral Health	2015	2016–2018

<sup>1</sup> Prior to 2012, Passport Health Plan was the sole Medicaid MCO and the contract required only one PIP annually.

<sup>2</sup> Final EQRO review of second re-measurement was sent to MCO 2/24/2015.

BCBS: Blue Cross and Blue Shield.



The EQRO's PIP reviews encompassed an evaluation of the study topic selection, indicators, methodology, interventions, data analysis and results as well as an overall impression of the PIPs' strengths and opportunities for improvement. Several recurring strengths were noted in the PIP review summaries including:

- § strong project rationale supported by literature citations and/or national and statewide statistics and plan-specific data;
- § selected topic demonstrates substantial opportunity for improvement;
- § strong evidence of topic relevance to the plan or a public health issue;
- § collaboration with external organizations;
- § use of a multi-disciplinary teams for project implementation;
- § interventions that address identified barriers; and
- § multi-dimensional interventions targeting providers, members and the health plan.

The EQRO's role in validating the PIP also involved identification of opportunities for improvement, and the following were recurring comments in the PIP reviews:

- § Indicators are not clearly defined or are not aligned with the study aims and objectives.
- § The interventions do not directly target the indicator(s).
- § A more active intervention strategy is needed as the proposed interventions are passive education activities such as mailings and website postings.
- § Process measures should be used to track the progress of the major interventions.
- § The intervention descriptions lack specifics, such as timeframes and logistics on implementation.

Anthem BCBS Medicaid did not have any PIPs at the interim or final phases that required scoring. They had two PIPs at the baseline phase that were submitted: Reducing Avoidable Emergency Department Utilization and Antipsychotic Medication Use in Children.

Aetna Better Health had two 2013 PIPs at the final measurement phase, Decreasing Non-Emergent/Inappropriate Emergency Department Utilization and Major Depression: Antidepressant Medication Management and Compliance. Both met the compliance requirements with recommendations and comments. Two PIPs were in the interim phase: Secondary Prevention by Supporting Families of Children with ADHD and Decreasing Avoidable Hospital Readmissions. Both of the PIPs met compliance requirements with recommendations. Aetna Better Health continues to meet with DMS and IPRO on a monthly basis.

Humana-CareSource had two PIPs in the interim phase of scoring: Untreated Depression and Emergency Dept: Use Management. Both PIPs met compliance.

Passport Health Plan's one 2014 PIP, Psychotropic Drug Intervention Program (PDIP), was at the interim phase during this contract year. The EQRO found that it met compliance requirements.

WellCare of Kentucky had two PIPs in the final phase: Utilization of BH Medicine in Children and Inappropriate ED Utilization. Both of these PIPs were found to be compliant. Two additional PIPs were in the interim phase. They are: Follow-up After Hospitalization for Mental Illness and Management of COPD. Both of these PIPs are currently compliant at this phase.

### **Focused Clinical Studies**

During the contract year, the EQRO initiated and completed two focused clinical studies: 1) Emergency Department Visits for Non-traumatic Dental Problems Among the Adult Kentucky Medicaid Managed Care Behavioral Health Subpopulation, and 2) Prenatal Smoking.

#### **Emergency Department Visits for Non-traumatic Dental Problems Among the Adult Kentucky Medicaid Managed Care Behavioral Health Subpopulation**

Administrative encounter data for measurement year June 1, 2014–May 31, 2015 were utilized to assess relationships between the outcome of an emergency department (ED) visit for non-traumatic dental problems and the risk factors among the adult (aged 18 years and older) MMC behavioral health (BH) subpopulation.

The following outcomes were evaluated among the total adult BH subpopulation: any (one or more) ED visit(s) for non-traumatic dental problems: disorders of tooth development and eruption; diseases of hard tissues of teeth (dental caries); disease of pulp and periapical tissues; gingival and periodontal diseases; other diseases of teeth and supporting structures.

In addition, among the subset of the population with non-traumatic dental visits (NTDV), associations between risk factors and the outcome of multiple NTDVs (MNTDVs) were evaluated. The risk factors examined included demographic characteristics (age group, race, sex); specific BH conditions; chronic physical health conditions; member region of residence (rural non-Appalachian, urban non-Appalachian, and Appalachian county); MCO; access to PCPs, access to BH providers for outpatient visits; and access to outpatient dental visits by type (restorative, preventive/diagnostic without restorative care; pain/palliative care without restorative care; and no outpatient dental visits).

Key findings included the following:

- § The majority of the BH MMC population with one or more NTDVs was between the ages of 18–37 years and resided in urban counties.
- § Unmet dental needs and lack of access to outpatient dental care crossed geographic boundaries.
- § Most Kentucky BH MMC members with an NTDV had no outpatient dental visits, yet the highest NTDV rate was among members with an outpatient dental visit for pain/palliative care without any restorative care.
- § There was significant variability in the NTDV rate among Medicaid MCOs and among members with and without outpatient visits to PCPs and BH providers.

### Prenatal Smoking

The aims of this focused clinical study included the following:

- § assess smoking prevalence, member characteristics, and receipt of prenatal smoking cessation services among the Kentucky MMC population who delivered a singleton live or non-live birth;
- § evaluate the relationships between smoking cessation benefit utilization and demographic, clinical and health care access characteristics;
- § identify clinical, demographic and smoking-related factors that impact selected adverse perinatal outcomes; and
- § profile provider prenatal and postpartum interventions relative to guidelines, including the 5 A's, MCO care coordination and case management of prenatal and postpartum interventions, whether or not smoking abstinence was achieved and, if it was achieved, whether it was achieved during the prenatal period or the postpartum period.

The study methodology comprised analyses of both administrative data and data abstracted from medical records. The administrative portion of the study examined the entire population of members who delivered a singleton live or stillborn infant, utilizing administrative claims/encounter data to evaluate disparities and associations. Smoking status was defined using ICD-9-Clinical Modification (ICD-9-CM) diagnosis codes across all settings of care during the 280 days prior to the delivery date.

The medical record portion of the study utilized a random sample of 500 members (424 member charts received) from the eligible aforementioned eligible population, stratified by smoking status and MCO (i.e., a population of smokers and nonsmokers from each of the five MCOs). The following data were abstracted from the medical records: provider documentation of the “5 A’s” in the prenatal and postpartum outpatient records, MCO documentation of care coordination/case management prenatal and postpartum interventions for smoking cessation, and both prenatal and postpartum smoking abstinence outcomes from both provider and MCO charts.

Key findings included the following:

- § The majority of members (89.97%) were assessed for smoking status during a prenatal visit; however, only 49.28% had an initial smoking assessment conducted at a first prenatal visit that occurred during the first trimester.
- § Less than half (46.98%) of prenatal smokers were advised to quit at any prenatal visit, 22.15% were advised to quit during the first trimester and 16.11% during the second trimester.
- § Only 2.01% of prenatal smokers were referred to the Kentucky quit line.

- § There were 57 (38.36%) of 149 smokers who received perinatal provider counseling; Of these 57 smokers, medical record documentation indicated that a total of 5 members quit smoking during pregnancy; 2 quit smoking with abstinence from the first trimester through delivery, 1 abstained from the second trimester through delivery, and 2 abstained from the third trimester through delivery.

## Early and Periodic Screening, Diagnosis and Treatment

EPSDT, a federally required Medicaid program for children, has two major components: EPSDT Screenings and EPSDT Special Services. The screening program provides well-child check-ups and screening tests for Medicaid eligible children in specified age groups. EPSDT special services are only provided when medically necessary, if they are not covered in another Medicaid program, or are medically indicated and needed in excess of a program limit. DMS contracts with Kentucky's EQRO to validate that the MCOs' administration of EPSDT benefits is consistent with federal and state requirements.

## Kentucky Medicaid Managed Care Early Periodic Screening, Diagnostic and Treatment Services (EPSDT) Review for 2015, Draft Report June 2016

The EQRO conducted a review of adherence to EPSDT protocol using MCO EPSDT data reports and review of a sample of complaints, grievances, denials and care management files. Other reports and data referenced included the Annual Compliance Review findings for the EPSDT domain, 2015 HEDIS (MY 2014 data) and Kentucky PMs (MY 2014 data), and MCO statutory reports (MY 2015). EPSDT programs for each of the five Kentucky Medicaid MCOs participating in 2015 were evaluated.

Statutory reports relevant to EPSDT services submitted by Kentucky MCOs included the following:

- § Quarterly Report #24 – Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death,
- § Annual Report #93 – EPSDT Annual Participation Report (as reported on CMS-416),
- § Quarterly Report #17 – Quality Assessment and Performance Improvement Work Plan,
- § Quarterly Report #85 – Quality Improvement Program Evaluation,
- § Annual Report #94 – CAHPS Medicaid Child Survey,
- § Annual Report #86 – Annual Outreach Plan,
- § Quarterly Report #18: Monitoring Indicators, Benchmarks and Outcomes, and
- § Quarterly Report #19, Performance Improvement Projects (PIPs).

Key findings included the following:

- § Kentucky MCOs were compliant with contractual requirements to inform members about the availability of EPSDT services and facilitate utilization; most demonstrated a multi-faceted approach to member education, utilizing a variety of educational mailings, personalized postcards pre- and post-service due dates, telephonic outreach, website postings, and presentation at community and back-to-school events.
- § Every MCO required PCPs to provide EPSDT services; four of five MCOs met all PCP network requirements for geographic access, member to PCP ratios, and appointment scheduling wait times.
- § Four of five MCOs were fully compliant regarding provider education conducted via provider manuals, websites, newsletters, resource guides, tool kits, and on-site visits. A recurring issue is the development of educational materials for non-physician providers such as nurses, nurse practitioners and physician assistants.
- § Four of five MCOs were compliant with monitoring provider delivery of EPSDT services through medical record review against Clinical Practice Guidelines, tracking provider-specific PM rates, and monitoring provider member panels for Care Gaps. With few exceptions, notably Passport Health Plan, MCO screening ratios by age group did not meet national averages and decreased with age, indicating primarily infants are receiving the expected number of screenings. A similar pattern was seen in participant ratios, indicating relatively more infants and toddlers received any screening services during the review period. HEDIS Access/Availability and Utilization of Care measures also demonstrated fewer PCP and well-care visits among adolescents compared to infants and toddlers.

## Summary of Program Progress – Strengths and Opportunities for Improvement

This report described the status and progress of the Kentucky MMC Program's external quality review activities that have occurred over the past twelve-month contract period of July 1, 2015 through June 30, 2016. During the contract period, numerous strengths as well as opportunities for improvement have been identified and are highlighted below.

### Strengths

#### Program Administration

- § Kentucky's MMC Program is composed of five MCOs with capacity to serve Medicaid enrollment statewide. Enrollment has steadily increased over the past year from 1,162,413 as of June 29, 2015, to 1,229,921 as of June 6, 2016, an increase of 5.8%.
- § With several leadership changes and increasing branch responsibilities for monitoring and quality improvement, DMS continues to vigorously apply staff resources and expertise in the development of their expanding MMC Program.
- § Kentucky continues to have a contract in place for external quality review, including work plan activities for the annual technical report, the three mandatory quality review activities and several optional activities, such as conducting focused quality studies and validation of MCO submitted data files.
- § There continues to be excellent lines of communication between the state, the MCOs and the EQRO.
- § DMS applied for and received acceptance to participate in several CMS Affinity Group collaboratives and a SAMHSA Tobacco Policy Group collaborative, which offer opportunities to expand state resources through collaboration with other state and national participants.

#### Data Systems

- § Data collection systems for all five Medicaid MCOs are in place including encounter data, provider network data, HEDIS and Kentucky PMs. All MCOs submitted data to DMS according to established timeframes.
- § Each month the EQRO received a final extracted encounter file from DMS and created a monthly Encounter Data Validation Report summarizing the MCO submissions. DMS continues to work with the MCOs, the EQRO and appropriate divisions of DMS to review MCO progress in encounter data quality and completeness and to troubleshoot issues in need of improvement.
- § MCOs commented that their communication with DMS regarding encounter data submissions continues to be positive and the monthly conference calls with DMS continue to be helpful.
- § DMS continues to update their internet website to include MCO data reports and external quality review reports.
- § The EQRO successfully completed four data validation reviews of the Kentucky MMC Program Provider Network, including two audits of Kentucky's Provider Network Submissions (September 2015 and March 2016) and two validations of MCO web-based provider directories in the same months.
- § The overall accuracy rates of the provider information published in the web directories was found to be 97% for PCPs and 77% for specialists.
- § Kentucky PMs, HEDIS and CAHPS data were successfully submitted by all MCOs in 2015 for services provided in the 2014 measurement year.
- § The EQRO validated the Kentucky PMs for reporting year 2015 and compiled all MCO HEDIS audit findings.
- § The EQRO summarized HEDIS 2015 quality performance data in Kentucky's consumer-friendly document entitled "A Members Guide to Choosing a Medicaid Health Plan." A copy of the guide is posted on the DMS website. A similar guide is also being developed with HEDIS and CAHPS 2016 data.

#### Compliance with State and Federal Standards

- § An annual compliance review was successfully completed in January 2016 by the EQRO for the calendar year January 2015–December 2015 for all five MCOs. Anthem and WellCare of Kentucky had full reviews.
- § The overwhelming majority of review areas for all plans (93%) exhibited overall substantial or full compliance.

- § Health Information Systems was not reviewed for the five MCOs since they received full compliance ratings in the previous compliance review.

### Provider Network Access

- § The EQRO conducted a telephone survey of provider appointment availability for dental providers using the “secret shopper” methodology. Overall, dental providers were contacted for 92.4% of routine calls and 88.2% of urgent calls. Dental providers were reached and appointments were scheduled within the required timeframes for 35.2% of routine calls and 31.6% of urgent calls (i.e., 21 days and 48 hours, respectively).
- § Overall, the adult and child CAHPS 2015 survey results showed strong consumer satisfaction with access to care under the Kentucky MMC Program, including ratings for Getting Care Quickly, Getting Needed Care, Customer Service and Doctor Availability.

### Quality Assessment

- § All five MCOs reported Kentucky PMs for reporting year 2015. The EQRO validated the Kentucky PMs for 2015.
- § All five MCOs successfully submitted audited HEDIS data in June 2015 for services provided in the 2014 measurement year.
- § Statewide results of the adult CAHPS 2015 survey indicated that 78.4% of adults were satisfied overall with their healthcare under managed which was above the 2015 national Medicaid average for overall satisfaction with healthcare. For the child survey, 82.5% of those surveyed were satisfied overall with their healthcare, falling just short of the CAHPS 2015 national Medicaid average.

### Performance Improvement

- § The EQRO reviewed all PIP proposals submitted by Kentucky Medicaid MCOs for 2015 and continues to validate all PIPs in progress through periodic conference calls with the MCOs.
- § Validation findings for all completed PIP reviews indicated that the credibility of the PIP results is not at risk after the revisions suggested by the EQRO were addressed.
- § The EQRO completed two related focused studies: 1) Emergency Department Visits for Non-traumatic Dental Problems among the Adult Kentucky Medicaid Managed Care Behavioral Health Subpopulation; and 2) Prenatal Smoking.

### Opportunities for Improvement

#### Data Systems

- § A monthly validation review of encounter data submissions continues to indicate a number of variables that consistently have a high percent of missing data elements including inpatient diagnoses codes 4 and above, inpatient procedure codes, inpatient surgical codes 2 and above, performing provider key, procedure modifier codes, referring provider key and outpatient surgical ICD-9 codes. Provider-related data was also missing several key elements including NPI, provider license number and taxonomy.
- § The audits of MCO provider network submissions indicated that close to half of the returned surveys noted at least one revision.

#### Compliance with State and Federal Standards

- § Anthem BCBS was required to submit 54 Corrective Action Plans (CAPs) for Minimal or Non-compliant elements, or 22.5% of total elements reviewed, followed by Aetna Better Health(4.3%), Humana-CareSource (1.5%), WellCare of Kentucky (.4%) and Passport Health Plan (0%).
- § In preparing Quarterly Desk Audit Tables as part of the compliance review, there continues to be a lack of consistency in MCO interpretations of the data specifications for reporting, thus making comparisons across MCOs difficult. The EQRO provided suggestions for revising report language and instructions to improve reporting consistency.
- § Of all elements reviewed for all five MCOs, 4.6% received minimal or non-compliant ratings requiring a corrective action plan. This is an overall improvement from last year's rate of 10.6%.
- § Overall Anthem BCBS received minimal compliance determinations for HRA, Care Management, Medical Records and Behavioral Health Services.



## Provider Network Access

- § The Access and Availability Survey of dental providers reported that appointments were scheduled within the required timeframes for 35.2% of routine calls and 31.6% of urgent calls (i.e., 21 days and 48 hours, respectively).
- § HEDIS 2015 statewide rates for Board Certification for all provider types fell below the HEDIS 2015 national NCQA Quality Compass 10<sup>th</sup> percentile rate.

## Quality Assessment

- § The process of summarizing selected quarterly report information across plans in the form of quarterly desk audits highlights the variability in the data reported and raises questions about how each of the MCOs are interpreting the questions. More data specification and interpretive guidance is needed, so that all MCOs are reporting consistently and a fair comparison can be made across plans.
- § Reported EPSDT screening rates dropped from 83% in RY 2014 to 82% in RY 2015. The reported participation rate for EPSDT services in RY 2015 was 58%, well below the 80% standard set by CMS. Results of the EPSDT validation study and HEDIS and Healthy Kentuckians measures indicated opportunities for improvement in mental health, vision, hearing, and developmental screening; depression and behavioral risk screening for adolescents; BMI screening and nutrition/physical activity counseling; immunizations and lead screening. Oral health assessment was also found lacking in the validation study.

## Performance Improvement

- § As a result of the Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity Clinical Focused Study, MCOs were encouraged to promote BMI percentile screening and universal prevention interventions for all MMC-enrolled children beginning in early childhood; to improve provider risk assessment, management and monitoring of overweight and obese enrollees; to ensure that resources for nutrition, physical activity and weight management are disseminated to network providers; and to educate members and families regarding cardiovascular and other health risks associated with overweight and obesity. It was further recommended that improvement efforts address obesity with a chronic care model that includes motivational interviewing, family involvement and engagement of all office staff in the care of at-risk children and adolescents.

## Recommendations

Focusing on the strengths and opportunities for improvement identified for the Kentucky MMC Program between July 1, 2014 and June 30, 2015, the following key performance area recommendations are presented for DMS's consideration.

## Data Systems

External quality review activities are strongly rooted in data quality including validations of performance data, encounter data and provider network data. The protocols for validating data require an assessment of multiple dimensions including:

- § Validity and accuracy – does the data reflect the real world?
- § Consistency – can the data be compared over time and between entities?
- § Completeness – is there missing data?
- § Timeliness – is the data available at the time needed?
- § Relevance – does the data meet the users' needs?

The quality of data collected and maintained by the MCOs is of critical importance in measuring program progress and achievements and for targeting improvement efforts. Missing codes in encounter data submissions and inconsistent performance rates as identified in the Encounter Data Rate Benchmarking Study adversely impact the usefulness of the data. Data elements should be clearly defined and specified. Inconsistent provider information in MCO and DMS Medicaid provider datasets needs to be continually audited and improved. Recommendations from the Provider Network Audits should be implemented to improve the usability of the provider data. The monthly encounter data meetings between DMS and the MCOs are valuable in helping the MCOs resolve encounter data submission problems and should be continued.



## Provider Network Access

HEDIS PMs and CAHPS satisfaction measures related to access were an area of strength for all five MCOs reviewed in this progress report; however, opportunities for improvement in the following HEDIS rates should be addressed:

- § Board Certification for all provider specialties,
- § Well-Child Visits in the First 15 Months of Life (6+ visits),
- § Well-Child Visits in the Three to Six Years of Life,
- § Adolescent Well-Care Visits, and
- § Initiation of AOD Dependence Treatment: 18+ years and Total.

## Quality Assessment and Performance Improvement

Using the national 2014 Medicaid Quality Compass as a benchmark, opportunities for improvement should be considered for the following HEDIS 2015 measures that fell below the national Medicaid 10<sup>th</sup> percentile:

- § Cervical Cancer Screening,
- § Appropriate Treatment for Children with Upper Respiratory Infection,
- § Annual Monitoring for Patients on Persistent Medications (Digoxin), and
- § Use of Imaging Studies for Low Back Pain.

Several Kentucky PMs which fell below 50% also offer opportunities for improvement:

- § healthy weight for height for both adults and children,
- § counseling for nutrition and physical activity for both adults and children/adolescents,
- § adolescent screening for depression,
- § screening for tobacco, alcohol use and substance use during the prenatal period,
- § prenatal assessment/counseling for nutrition and prenatal counseling for use of prescription and/or over the counter medications, and
- § prenatal screening for domestic violence, prenatal screening for depression and postpartum screening for depression.

With results from the Kentucky Behavioral Health Study and the Experience of Care Survey for Children with a Behavioral Health Condition, DMS may want to consider potential new measures that have been under review by NCQA such as, body mass index screening and follow-up for people with SMI; clinical depression screening and follow-up for people with alcohol or other drug dependence use; controlling high blood pressure for people with SMI; and follow-up after emergency department use for mental illness or AOD dependence.

## Care Coordination

All MCOs faced challenges in obtaining health risk assessments. General issues identified were: lack of documentation of assistance with PCP linkage and/or referrals to case management for identified needs. Care management review findings further revealed the need to develop and implement policies and procedures to ensure access to care coordination for all DCBS clients and to track, analyze, report and implement corrective actions regarding care coordination of DCBS clients. As noted in prior years, each of the MCOs faced challenges related to obtaining complete service plans but all demonstrated efforts to obtain the plans and to meet with DCBS regularly. While there has been substantial improvement in care coordination and communications between state agencies and MCOs, DMS needs to continue efforts to coordinate and maintain those improved communications.